2025 Benefits at A Glance.

Serving Maricopa and Pima County, Arizona

eternalHealth™

The Next Generation of Medicare Advantage

eternalHealth is an HMO plan with a Medicare Contract for HMO, HMO-POS and PPO offerings. Enrollment in eternalHealth depends on contract renewal. Benefits and cost sharing vary by plan. eternalHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. To file a complaint with eternalHealth, call us at 1 (800) 464-7198 (TTY 711). To file a complaint with Medicare, call 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048, 24 hours/7 days a week. If your complaint involves a broker or agent, be sure to include their name when you file your complaint. This is not a complete list of benefits. Out-of-network providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your evidence of coverage for more information, including the cost-sharing that applies to out-of-network services.

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Plan Costs	Horizon (HMO)		Grand Give Back (HMO)		Valor Give Back (HMO-POS)	
	In-Network		In-Network		In-Network	Out-of-Network
Monthly Premium	$0		$0		$0	
MOOP	$3,350		$4,550		$5,500	$9,000 Combined
Part B Give Back	N/A		$80		$100	
Medical Deductible	N/A		N/A		N/A	
INPATIENT CARE						
Inpatient Hospital	$150; Days 1-7		$325; Days 1-5		Medicare Defined	
Inpatient Mental	$150; Days 1-7		$325; Days 1-5		Medicare Defined	
Skilled Nursing Facility	$0; Days 1-20 $203; Days 21-100		$0; Days 1-20 $203; Days 21-100		Medicare Defined	
OUTPATIENT CARE						
Primary Care Visit	$0		$0		$0	
Specialist Visit	$0		$15		$0	$25
Chiropractor Visit	$20		$20		$20	50% coinsurance
Podiatry Visit	$20		$25		$20	50% coinsurance
Outpatient Mental Health	$15		$20		20% coinsurance	50% coinsurance
Outpatient Substance Abuse	$20		$20		20% coinsurance	50% coinsurance
Ambulatory Surgery Visit	$100		$140		20% coinsurance	50% coinsurance
Outpatient Hospital	$0 for diagnostic colonoscopy $150 for observation $175 for all other services		$0 for diagnostic colonoscopy $185 for observation $225 for all other services		20% coinsurance	50% coinsurance
Ambulance (Ground/Air)	$250		$270		20% coinsurance	50% coinsurance
ER Includes Worldwide Coverage	$135		$120		You pay 20% coinsurance up to a maximum of $120 for each visit.	
Urgent Care Includes Worldwide Coverage	$0		$25		You pay 20% up to a maximum of $60 for each covered office visit to providers for urgently needed services.	
Home Health Services	$0		$0		$0	50% coinsurance
OUTPATIENT MEDICAL SERVICES AND SUPPLIES						
Durable Medical Equipment	20% Coinsurance		20% Coinsurance		20% coinsurance	50% coinsurance
Diabetic Supplies	20% Coinsurance		20% Coinsurance		20% coinsurance	50% coinsurance
Diagnostic Lab	$0		$0		20% coinsurance	50% coinsurance
Diagnostic Procedures	$0 at office $60 at free standing lab facility		$0 at office $60 at free standing lab facility		20% coinsurance	50% coinsurance
Medicare-covered Diagnostic Radiological services	$75 Ultrasound $170 all others		$115 Ultrasound $225 all others		20% coinsurance	50% coinsurance
Medicare Covered X-Ray	$0		$0		20% coinsurance	50% coinsurance
Diagnostic Colonoscopy	$0		$0		20% coinsurance	50% coinsurance
Therapeutic Radiology	$60		$60		20% coinsurance	50% coinsurance
PREVENTATIVE SERVICES						
Preventive Services	$0		$0		$0	$0
PART D						
Deductible	$200 for tiers 4 and 5		$400 for tiers 4 and 5		N/A	
	Retail (30d|100d)	Mail (30d|100d)	Retail (30d|100d)	Mail (30d|100d)		
Tier 1	$0 | $0	$0 | $0	$0 | $0	$0 | $0		
Tier 2	$5 | $15	$5 | $10	$5 | $15	$5 | $10		
Tier 3	$45 | $135	$45 | $90	$45 | $135	$45 | $90		
Tier 4	28% | 28%	28% | 28%	28% | 28%	28% | 28%		
Tier 5	30% | 30%	30% | 30%	28% | 28%	28% | 28%		
Insulin	$35 | $105	$35 | $70	$35 | $105	$35 | $70		
EXTRA BENEFITS						
Dental	$3,500 annual allowance		$3,000 annual allowance		$2,500 annual allowance	
Vision	$0 Routine Vision Exam $20 Medicare Covered Exam $200 Eyewear Allowance Annually		$0 Routine Vision Exam $25 Medicare Covered Exam $200 Eyewear Allowance Annually		$0 Routine Vision Exam (INN only) 20% coinsurance (INN) | 50% coinsurance (OON) Medicare Covered Exam $200 Eyewear Allowance Annually	
Hearing	$0 Routine Hearing Exam $20 Medicare Covered Exam $595/$895 Copay Per Ear Annually		$0 Routine Hearing Exam $25 Medicare Covered Exam $595/$895 Copay Per Ear Annually		$0 Routine Hearing Exam (INN only) 20% coinsurance (INN) | 50% coinsurance (OON) Medicare Covered Exam $595 or $895 Copay Per Ear Annually (INN)	
OTC Allowance	$60 Quarterly; Does not carry over		$70 Quarterly; Does not carry over		$50 Quarterly; Does not carry over	
Healthy Grocery Allowance*	$50 Quarterly which can combine with OTC allowance; Does not carry over		Not covered		Not covered	
Essentials Wallet*	Not covered		Not covered		$300 Quarterly which includes Healthy Grocery Allowance. Wallet can be used towards grocery, rent/mortgage, utilities, automobile gas and minor home and bathroom safety modifications.	
Reduction In Cost Sharing (RICS)	$200 Quarterly to use towards medical expenses.		Not covered		Not covered	
Transportation	Unlimited transportation to and from the pharmacy, dentist and medical appointments at no additional cost.		Unlimited transportation to and from the pharmacy, dentist and medical appointments at no additional cost.		24 one-way trips to and from the pharmacy, dentist and medical appointments at no additional cost.	
In-Home Support	Up to 60 hours annually for assistance with household chores, technical assistance, and general companionship. Virtual companionship is also available.		Not covered		Not covered	
Fitness Flex Allowance	Not covered		Not covered		$300 Annually to use towards fitness activity, pickleball, tennis, golf, yoga and dance fees plus cover the cost of fitness supplies and wearable items,	
Fitness	Access to national and boutique fitness facilities, on-demand classes, social activities, brain training, and at-home fitness kits.					
Routine Chiropractic and Acupuncture services	Not covered		$25 copay per visit. Limit of 20 visits per calendar year combined.		$25 copay per visit. Limit of 20 visits per calendar year combined.	
Therapeutic Massage	Not covered		$20 copay per visit. Limit of 20 visits.		Not covered	
Meals	14 days/28 meals upon discharge. Must be approved by plan prior to placing order.		14 days/28 meals upon discharge. Must be approved by plan prior to placing order.		14 days/28 meals upon discharge. Must be approved by plan prior to placing order.	
PERS	Fully covered monthly subscription. (In-home, Mobile LTE, and LTE Smartwatch options)		Fully covered monthly subscription. (In-home, Mobile LTE, and LTE Smartwatch options)		Not covered	

**Members must qualify to receive this benefit. Not all members will qualify.*